

Federation of State Medical Boards

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Federation of
**STATE
 MEDICAL
 BOARDS**



Celebrating 100 years of
 service, partnership,
 1912-2012 leadership, and innovation

Dear Colleague:

Following the 2013 Annual Meeting, FSMB's incoming Chair, Jon Thomas, MD, will finalize appointments to the Audit, Bylaws, Editorial, Education, Ethics and Professionalism, and Finance Committees, and potentially to an FSMB Special Committee(s).

Committee responsibilities and time commitments vary, but to complete their charges successfully, all committees require dedicated and knowledgeable members. To begin the appointment process, individuals interested in serving on a committee, or those wishing to recommend an individual, should submit letters of interest/recommendation by **January 7, 2013** via mail, fax or email to:

Jon Thomas, MD, Chair-elect
 Federation of State Medical Boards
 c/o Pat McCarty, Director of Leadership Services
 400 Fuller Wiser Road, Suite 300
 Euless, Texas 76039-3855
 Fax: (817) 868-4167
 Email: pmccarty@fsmb.org

Additionally a copy of the individual's CV (a maximum of five pages) and/or biographical sketch, including state medical board and/or FSMB experience, should be forwarded to the email above accompanied by a **photograph – color or black/white (jpg is preferred but hard copies are acceptable)**. Copies of the photos will be included with the materials Dr. Thomas will be reviewing as he considers his appointments. Those appointed to committees also will have their photos posted on the FSMB website.

A confirmation acknowledging receipt of appointment recommendations will be sent within one week. If you do not receive confirmation, please contact Pat McCarty at (817) 868-4067 or by email.

Sincerely,
 Humayun J. Chaudhry, DO, FACP
 President and CEO

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Dear Member Board Presidents/Chairs and Executive Directors/Secretaries,

Member medical boards wishing to submit resolutions for consideration at the FSMB's April 20, 2013 House of Delegates annual business meeting are requested to forward all proposed resolutions to the FSMB. **The deadline for submission of resolutions for the 2013 meeting is February 15, 2013.**

Resolutions must be:

- Submitted in writing via mail, fax or e-mail to the FSMB at least 60 days prior to the annual business meeting of the House of Delegates.
- Sent to:

Humayun J. Chaudhry, D.O., FACP
President and CEO
c/o Pat McCarty, Director of Leadership Services
The Federation of State Medical Boards
400 Fuller Wiser Road, Suite 300
Euless, Texas 76039-3855
Fax: (817) 868-4167
E-mail: pmccarty@fsmb.org

Confirmation will be sent to you upon receipt of your resolutions. **If you do not receive confirmation within one (1) week, please contact Pat McCarty at (817) 868-4067 or by email as stated above.**

When drafting resolutions for submission, please give close attention to the following:

- As stated in the FSMB Bylaws, "...the right to introduce resolutions is restricted to Member Medical Boards and the Board of Directors and the procedure for submission of such resolutions shall be in accordance with FSMB Policy."
- The title of the resolution should appropriately and concisely reflect the action for which it calls.
- The date on which the resolution was approved by the state medical board should appear beneath the title.
- Information contained in the resolution should be checked for accuracy.
- The "resolved" portions should stand alone, since the House adopts only the "resolved" portions and the "whereas" portions are not subject to adoption.

A sample resolution is attached for your information. Also attached for your review is information regarding the FSMB's House of Delegates policy development process.

In order to ensure prompt distribution of your resolutions to FSMB member boards for review, we would appreciate your cooperation in sending them to us as soon as they are available. Resolutions will also be posted on the FSMB website.

Maintenance of Licensure: Supporting a Physician's Commitment to Lifelong Learning

Humayun J. Chaudhry, DO, MS, SM; Lance A. Talmage, MD; Patrick C. Alguire, MD; Frances E. Cain, BA; Sandra Waters, MEM; and Janelle A. Rhyne, MD, MA

Initially focused on preventing the unlicensed practice of medicine by “quacks” and “charlatans,” state medical boards evolved necessarily over time to promote higher standards for undergraduate medical education; require assessment of knowledge and skills to qualify for initial licensure; develop and enforce standards for professional discipline; and, beginning in 1971, promote continuing medical education (CME). More than a century ago, state medical boards were instrumental in securing legislation that authorized them to refuse to examine graduates of poor-quality medical schools—even before the 1910 publication of Abraham Flexner’s scathing indictment of proprietary schools, which hastened their demise and closure (1, 2). Twenty years ago, the Federation of State Medical Boards (FSMB) partnered with the National Board of Medical Examiners to create the 3-step United States Medical Licensing Examination (which includes a clinical skills component added in 2004) as a qualifying examination for initial licensure accepted by all state medical boards (osteopathic physicians typically take the Comprehensive Osteopathic Medical Licensing Examination of the National Board of Osteopathic Medical Examiners).

When the FSMB’s House of Delegates voted in 2010 to adopt a framework for Maintenance of Licensure (MOL), it was a seminal event because the primary focus of medical licensure up to that point had been the rigorous sequence of decision points and milestones—from admission into medical school through postgraduate training—that lead to the initial privilege to practice medicine. Although CME was first required for licensure renewal in New Mexico in 1971, and nearly all state medical boards now require a prescribed number of accredited CME credit hours (and sometimes content-specific CME), the process by which physicians maintain licensure has remained a concern among policymakers and regulators, particularly as the knowledge and skills needed to practice medicine grow exponentially. The MOL framework helps address these concerns by envisioning 3 components (reflective self-assessment, assessment of knowledge and skills, and performance in practice) that would be periodically required of actively licensed physicians in their area of practice for them to renew their license.

The earliest calls to reform licensure renewal date back to 1967, when the National Advisory Commission on Health Manpower recommended that “state governments . . . explore the possibility of periodic relicensing of physicians and other health professionals” (3). In a report 4

years later, the U.S. Department of Health, Education, and Welfare (now the Department of Health and Human Services) noted that state boards provide a *de facto* lifelong medical license to most physicians and that state requirements were adequate as safeguards for entry into the profession but ineffective against “professional obsolescence” (4). These recommendations encouraged state medical boards to eventually adopt CME requirements. In more recent years, the Pew Charitable Trusts and the Institute of Medicine separately called for “continuing competency requirements” and “a mechanism to ensure that practitioners remain up to date with current best practices” to improve patient safety and reduce medical errors (5–7).

With a national shortage of physicians and more than 30 million people soon eligible for health insurance under the Patient Protection and Affordable Care Act, striking the right balance between what is necessary to protect the public and promote quality health care—the primary mission of state medical boards—and what will be administratively reasonable for practicing physicians to demonstrate their commitment to lifelong learning without substantively disrupting patient care has been a priority of the FSMB and its state boards as they consider the specific means by which physicians will be able to meet MOL requirements. A series of guidelines adopted alongside the MOL framework has guided these deliberations (Table).

THREE MOL COMPONENTS

The 3 components of MOL incorporate the core competencies for physicians adopted by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties (ABMS) in 1999 (8). Although states will not mandate a high-stakes, secure examination for MOL, the FSMB has begun to identify various educational and practice improvement activities across all specialties and areas of practice that could satisfy a state’s MOL requirements.

The first component, reflective self-assessment (“What improvements can I make?”), relies heavily on a physician’s participation in CME, which could be supplemented by such self-review exercises as home-study courses or Web-based activities, including reviews of the literature in the physician’s area of practice. The second component, assessment of knowledge and skills (“What do I need to know and be able to do?”), could be met by completion of computer-based case simulations; performance improvement CME; procedural hospital credentialing; or the com-

Table. MOL Guiding Principles*

Maintenance of Licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.
Maintenance of Licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.
Maintenance of Licensure should not compromise patient care or create barriers to physician practice.
The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.
Maintenance of Licensure processes should balance transparency with privacy protections.

MOL = Maintenance of Licensure.

* Guiding principles were adopted by the House of Delegates of the Federation of State Medical Boards in 2010 and were obtained from the Federation of State Medical Boards MOL Information Center (www.fsmb.org/mol.html).

pletion of performance improvement activities offered by the Institute for Healthcare Improvement, American Medical Institute, or American College of Physicians (for example, the Medical Knowledge Self-Assessment Program), to name 3 examples. The third component, performance in practice ("How am I doing?"), could be evaluated with patient and peer surveys; such activities as ABMS practice improvement activities or the Clinical Assessment Program of the American Osteopathic Association; 360-degree multisource evaluations; or, over time, submission of practice activities adhering to regional or national performance improvement benchmarks. The third component may be facilitated in the coming years by the adoption of electronic health records, which would enable easier volunteer sharing of practice performance information with state boards.

The overriding philosophy of the timeline for MOL implementation can best be summarized as "evolutionary, not revolutionary." The FSMB's MOL Implementation Group has recommended that state boards spend at least a year educating physicians and the public about their MOL plans before implementing them (9). The group also suggested implementing each of the 3 components sequentially over time, rather than all at once, allowing 2 to 3 years for each component to be fully implemented (although state boards may wish to implement the program faster if they are able). Finally, the group recommended that activities in the first component, such as CME, be required annually, but that activities in the second and third components be reported to state boards no more often than every 5 to 6 years. If all of these recommendations are followed, the earliest that the state boards could begin to implement an MOL program (or, at the least, its first component) would be 2014.

THE VALUE OF SPECIALTY CERTIFICATION

As state boards consider recommendations for physician participation in MOL, it is apparent that many of the activities required by specialty boards to maintain certification already meet, if not exceed, the requirements that state

boards are seeking for MOL (10). In 2011, the FSMB's MOL Implementation Group recommended that physicians actively engaged in the Maintenance of Certification program of the ABMS or the Osteopathic Continuous Certification program of the American Osteopathic Association Bureau of Osteopathic Specialists be recognized as having substantially fulfilled the requirements of all 3 components of any state's MOL. For most specialty-certified physicians—comprising well more than half of the nation's 850 085 actively licensed allopathic and osteopathic physicians (11)—meeting the requirements for MOL could be as simple as providing an attestation of their ongoing participation in certification maintenance activities of the ABMS or American Osteopathic Association Bureau of Osteopathic Specialists.

Because more than 230 000 physicians are not specialty certified in the United States, and physicians "grandfathered" for specialty certification (that is, physicians who have certificates that do not expire) are not required to participate in the Maintenance of Certification or Osteopathic Continuous Certification programs, the FSMB and collaborating organizations are working to identify, and in some cases develop, activities and tools to enable these physicians to meet MOL requirements. This will be important for specialty-certified physicians who elect not to participate in the Maintenance of Certification or Osteopathic Continuous Certification programs, which, like specialty certification, remain activities that will not be required for medical licensure.

Although a few important elements of MOL implementation remain to be worked out, such as what should be required of non-clinically active physicians, state medical boards are proceeding with the MOL initiative with the intent of contributing to quality health care through support of quality improvement and continuous professional development activities for all licensed physicians.

From the Federation of State Medical Boards, Eulless, Texas; South East Area Health Education Center, Wilmington, North Carolina; American College of Physicians, Philadelphia, Pennsylvania; and University of Toledo, Toledo, Ohio.

Potential Conflicts of Interest: Disclosures can be viewed at www.aecponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M12-0364.

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Current author addresses and author contributions are available at www.annals.org.

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